Liberty Health Cover

Disease Management Application Form

LIBERTY

LIFE INVESTMENTS INSURANCE **HEALTH** PROPERTIES ADVICE

FOR OFFICIAL USE ONLY Member/ policy number

Important: please read the following before completing this application form
- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.
- Please submit your completed form to our Liberty Health Cover in-country office.

1. PERSONAL DETAILS | PRINCIPAL MEMBER OR POLICYHOLDER

Please complete in block capitals

Last name

First names Title

Medical Insurer

Membership or policy number

ID/ Passport number

2. GENERAL PATIENT INFORMATION

Please complete in block capitals

Patient's last name

Patient's first name(s)

Patient dependant code Gender M F

Date of birth Y Y Y Y M M D D

Home telephone (please include country and area code) +

Mobile (please include country and area code) +

Fax (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

3. DOCTOR AND PROVIDER DETAILS

Please complete in block capitals

Hospital name

Speciality

Treating doctor's last name

Treating doctor's first name(s)

Speciality

Practice/Registration No.

Work telephone (please include country and area code) +

Fax (please include country and area code) +

Mobile (please include country and area code) +

E-mail

Physical address

Postal code

Postal address (if different to physical address)

Postal code

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DIAGNOSIS DETAILS

Please complete in block capitals

Date of diagnosis Y Y Y Y M M D D

Test used to diagnose

Counselling provided to patient Y N

WHO staging

HIV/Aids-related symptoms

Nervous system

Ear, nose, throat

Respiratory

Gastrointestinal

Urogenital

Skin

General

Weight (kg) Height (cm) BMI

TEST RESULTS

CD4	%	Viral Load	Date of test
			Y Y Y Y M M D D
			Y Y Y Y M M D D
			Y Y Y Y M M D D
			Y Y Y Y M M D D

OTHER TEST RESULTS

Name of test	Results	Date of test
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D

ANTIRETROVIRAL AND PROPHYLACTIC MEDICATION REQUESTED

Name	Strength e.g. 30mg	Directions e.g. bd

PREVIOUS ANTIRETROVIRAL MEDICATION

Name	Started	Stopped	Reason for stopping
	Y Y Y Y M M D D	Y Y Y Y M M D D	
	Y Y Y Y M M D D	Y Y Y Y M M D D	
	Y Y Y Y M M D D	Y Y Y Y M M D D	
	Y Y Y Y M M D D	Y Y Y Y M M D D	

SURGICAL/ MEDICAL / OBSTETRIC HISTORY

HOSPITAL ADMISSIONS

Diagnosis/ Procedure	Treatment	Date of admission
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D

TEST FOR TUBERCULOSIS

Date	Results	Treatment
Y Y Y Y M M D D		
Y Y Y Y M M D D		
Y Y Y Y M M D D		
Y Y Y Y M M D D		

TEST FOR MALARIA

Treatment	Results	Date
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D

Allergies to medication/ other

Currently pregnant Y N EDD Gravida Para

Current method of contraception

ACKNOWLEDGEMENT BY EXAMINING DOCTOR

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Having conducted a personal medical examination, I certify that the particulars are, to the best of my knowledge and belief, true and accurate . I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

Doctor's last name

Doctor's first name

Doctor's signature

Date Y Y Y Y M M D D

PATIENT'S DECLARATION

I hereby declare that the information in this form is true and correct. I am aware that the Insurer may request medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires.

In order to fully assess this application for benefits, I hereby give my consent for the Insurer to obtain this information. I understand that this application is subject to the Liberty Health Cover Policy Conditions and benefits.

Patient's signature

Date Y Y Y Y M M D D